STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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F0000	This visit was for the Investigation of Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F431. Complaint IN00113621 - Substantiated. Federal/state deficiencies related to the allegations are cited at F315, F322, F328, F329, F332, F425, and F431. Complaint IN00114469 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F431. Unrelated deficiencies are cited. Survey dates: August 19, 20, and 21, 2012 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Survey team: Jennie Bartelt, RN Census bed type: SNF: 0	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for survey ending July 30, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allecgation of compliance. Thus, the facility respectfully requests the granting of paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 75 Total: 75 Census payor type: Medicare: 14 Medicaid: 59 Other: 2 Total: 75 Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 27, 2012 by Bev Faulkner, RN			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to assess and plan care for a resident with history of benign prostatic hypertrophy related to urinary retention when the resident's Foley catheter was removed upon hospital discharge and when the physician ordered assessment for post void residual. The deficient practice affected 1 of 1 resident reviewed related to care following removal of Foley catheter from a sample of 11. (Resident I) Findings include: The clinical record for Resident 'I' was reviewed on 8/21/12 at 3:15 p.m. The record indicated the resident had a history of prostatic hypertrophy and had been in the hospital for surgery to the foot. The urologist's orders from the discharging hospital on 8/14/12 at 11:30 a.m., indicated, "[Illegible word] [check	F0315	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident 1 no longer resides in the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice** All residents with foley catheters were assessed and care plan updated by DNS/designee related to urinary retention, and post void residual.**Licensed nurses will be educated on the policy/ procedure for foley catheter care by the DNS/designee, post test included on or before 9/20/12Any resident that has a foley catheter removed will be assessed per physician order. The charge nurse will be**	09/20/2012

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	mark] PVR's [post void residuals] X 2 [twice] [secondary to] removal. Reanchor Foley if > [greater than] 300." The attending physician's orders from the discharging hospital on 8/14/12 at 12:55 p.m., included, but were not limited to, "Send to Hillcrest" and "Follow PVR [post void residual] orders at Hillcrest." A notation on the hospital transfer form indicated, "F/C [Foley catheter] out 11:30 [check mark] PVR X 2 Reanchor FC if PVR > 300." The American Senior Communities Admission Assessment indicated the resident was admitted on 8/14/12 at 6:00 p.m. The assessment indicated the resident did not have a Foley catheter and was not continent prior to admission. The Interim/Admission Nursing Care Plan, dated 8/14/12, failed to indicate a problem, goal, or interventions related to the resident's care need in regard to the recent removal of the Foley catheter and need for monitoring for urinary retention and checking for post void residual. Physician's admission orders, dated 8/14/12, included, but were not limited to, "F/C out 11:30, [check mark] PVR X 2. Reanchor F/C if PVR > 300."		**responsible for monitoring the 3 day Bladder Continent Assessment and ensuring post void residuals are completed per order. DNS/designee will monitor compliance by reviewing the 3 Day Bladder Continent Assessment upon completion. Non-compliance with these procedures will result in further education including disciplinary action. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be educated on the policy/ procedure for foley catheter care by the DNS/designee, post test included on or before 9/20/12Any resident that has a foley catheter removed will be assessed per physician order. The charge nurse will be responsible for monitoring the 3 day Bladder Continent Assessment and ensuring post void residuals are completed per order.DNS/designee will monitor for compliance Non-compliance with these procedures will result in further education including disciplinary action. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance**	

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	The first Nurse's Note, dated 8/14/12 at 10:00 p.m., included an assessment of the resident. Related to the urinary system, the note indicated, "...Pt has not void [sic] since being admitted [a period of four hours at the time of the note or 10+ hours since the Foley catheter was removed at the hospital], drainage & blood noted on penis...." The next Nurse's Note, dated 8/15/12 at 4:00 a.m., indicated related to the resident's urinary system: "Cont [continent] of B&B [bowel and bladder]," and was signed by RN #11. The next Nurse's Note, dated 8/15/12 at 11:00 a.m. indicated an assessment of the resident, including, "...Incont [incontinent] B&B [bowel and bladder]....Res. noted some anxiety. MD notified. Stated will be in to see res this afternoon." Documentation in Nurse's Notes from admission through 8/15/12 at 11:00 a.m., failed to indicate assessment and care provided related to possible urinary retention, including bladder distension when the resident failed to void, checking post void residual, including amount of void, amount of post void residual, or description of the urine.		**program will be put into place?** The CQI skills validation tool for foley catheters will be utilized weekly x 4 weeks, monthly x 6 months and quarterly thereafter Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold.. **CQI team will determine need for further review**	

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	The ADL [Activities of Daily Living] indicated only blanks for Bladder Function on 8/14/12. On 8/15/12, in the Continent column on night shift was indicated, "F/C." In the Incontinent column on 8/15/12 was indicated "1,200" on night shift and X 3 on day shift and a blank space on evening shift. On the Medication Record next to the entry for "F/C out 11:30, [check mark] PVR X 2. Reanchor F/C if PVR > 300," were a nurse's initials signed on the line between the dates of 8/12 and 8/13/12 and between the dates on the line of 8/13 and 8/14/12, both prior to the resident's admission. The time/shift of the catheterization could not be determined, as the documentation was written across lines for three shifts. After the initials each time was written 200. On the line for day shift (7:00 a.m. to 3:00 p.m.) on 8/15/12 were a nurse's initials with 800 cc next to the initials. The next Nurse's Note, dated 8/15/12 at 1:00 p.m., indicated, "MD in to see. N.O. [new order] Alprazolam [antianxiety medication]....Anchor F/C and D/C [discontinue] in 5 days then redo PVRs...." The Nurse's Note for 8/15/12 at 5:00 p.m., indicated a Foley catheter was placed.			

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Nurse's Notes for 8/18/12 at 11:45 a.m., indicated the resident was sent to the hospital for evaluation.

Nurse's Notes for 8/18/12 at 5:00 p.m., indicated the resident was admitted to the hospital for treatment of a urinary tract infection.

The Administrator, Director of Nursing (DON), Nurse Consultant, Director of Nursing from a sister facility, and Medical Records Nurse were interviewed about Resident I's care related to removal of the Foley catheter and the potential for urinary retention on 8/21/12 at 5:15 p.m. The Administrator indicated the facility had no policy on checking for post void residual. The DON from the sister facility indicated she would expect the checks for post void residual to be completed within the first shift after a Foley catheter was removed. She indicated if the resident had not voided, he would need to be assessed for urinary retention, such a assessing for a distended bladder. The Medical Records Nurse indicated the initials on the Medication Record were RN #11's initials. The Medical Records Nurse indicated she was phoning RN #11, and RN #11 told the Medical Records Nurse she thought she had completed the checks for post void residual checks on

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	8/15/12 at about midnight and 4:00 a.m. The Administrator stated to the Medical Records Nurse on the phone, "Tell her I want a written statement about it." The American Medical Directors Association's Clinical Practice Guideline for Urinary Incontinence indicated related to Postvoid Residual Testing, "When urinary retention is suspected on the basis of history, physical exam, or risk factors..., a postvoid residual (PVR) rest may be helpful. The test should be performed within a few minutes after a continent or incontinent void. Preferably, the volume of the void should be measured, but if it is an incontinent void, the amount of incontinence (i.e. small, medium, or large) should be recorded along with the PVR volume. A residual volume that is not measured within a few minutes after a void is not helpful...." This federal tag is related to Complaint IN00113621. 3.1-41(a)(1) 3.1-41(a)(2)			

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F0322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation and record review, the facility failed to ensure residents who received nutrition by gastrostomy tube were provided medications by gastrostomy tube in accordance with acceptable practice for 2 of 2 residents observed receiving medication by gastrostomy tube in a sample of 11 residents. (Residents D and F) Findings include: 1. On 8/19/12 at 10:05 a.m., LPN #15 was observed preparing medications for administration by gastrostomy tube to Resident D. LPN #15 crushed the medications, gathered the medications and supplies, and entered the resident's room. In the resident's bathroom, she poured the crushed medications into a cup and mixed with warm water. She mixed a powdered medication in a cup with warm water, and obtained a cup of water for flushing the resident's gastrostomy tube.	F0322	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident D and Resident F are now receiving medications via g-tube per acceptable nursing practices.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents recieving medications per g-tube have the potential to be affected by the alleged deficient practice.Residents receiving medications per g-tube were assessed by DNS/designee to ensure residents are receiving medications in accordance with acceptable practices. Licensed nurses will be educated on administering medications per g-tube by the SDC/designee on or before 9/20/12, post test includedlicensed nurses will be**	09/20/2012

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	LPN #15 donned gloves, stopped the resident's feeding pump for her nutrition by feeding tube and disconnected the feeding tube from the pump tubing. Without checking tube placement or flushing the gastrostomy tube, LPN #15 administered the cups of crushed and powdered medications in solution, flushed the tube with water, reconnected the feeding pump tube, and restarted the resident's feeding. 2. On 8/19/12 at 10:45 a.m., LPN #15 was observed preparing medications by gastrostomy tube for Resident F. LPN #15 crushed the medications and prepared powdered and liquid medications, and entered Resident F's room. She mixed the medications with water in cups. LPN #15 donned gloves, stopped the continuous tube feeding pump, disconnected the gastrostomy tube from the pump, and without checking placement or flushing the tube, poured the cups of crushed and powdered medications mixed with water into the tube, flushed with water and reconnected the tube and started the feeding. The facility policy related to Medication Administration Guidelines Via Enteral Tubes was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy indicated, "...Turn off the		**observed adminsitering medications per g-tube bythe SDC/designee on or before 9/20/12 with a skills validation completedDNS/designee will monitor for compliance**Non-compliance with this procedure will result in further training including disciplinary action. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be educated on administering medications per g-tube by the SDC/designee on or before 9/20/12, post test includedlicensed nurses will be observed adminsitering medications per g-tube bythe SDC/designee on or before 9/20/12 with a skills validation completedDNS/designee will monitor for compliance**Non-compliance with this procedure will result in further training including disciplinary action.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI audit tool for g-tube administration will be completed weekly x4 weeks, monthly x 6 months and quarterly thereafter** Findings	

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	feeding pump. Disconnect the feeding tubing from the enteral tubing....Check for feeding tube placement by aspiration of gastric contents or by auscultation (forcing air into the tube and listening to establish that it is in the stomach, rather than the lung)....Flush tube before medication administration with approximately 30 ml of water.... This federal tag is related to Complaint IN00113621. 3.1-44(a)(2)		from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold. The CQI team will determine need for further review.	

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F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to ensure assessment and planning of care for residents with respiratory care needs for 2 of 2 residents reviewed related to respiratory medications by nebulizer in a sample of 11 residents. (Residents C and F) Findings include: 1. On 8/19/12 at 10:45 a.m., LPN #15 was observed preparing and administering medications for Resident F, including a medication labeled Budesonide INH 0.5 mg/2ml, use 1 vial per nebulizer twice daily. At the resident's bedside, the nurse checked the resident's vital signs, obtained the resident's nebulizer mask, poured the medication into the medication chamber, assisted the resident with the mask, and started the treatment. The nurse did not assess the resident's breath	F0328	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident C and F are now receiving respiratory care based on their assessed needs and plan of care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents recieving nebulizer treatments have the potential to be affected by the alleged deficient practice**All residents receiving medications by nebulizer were assessed and care plan updated by DNS/designee to ensure residents are receiving medications as prescribed and per acceptable practices. **Licensed nurses will be educated on administering/assessing a resident recieving a nebulizer**	09/20/2012

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	sounds. 2. The clinical record for Resident C was reviewed on 8/20/12 at 5:30 p.m. Nurse's Notes for 8/10/12 at 10:15 a.m. indicated the resident experienced shortness of air with oxygen saturation at 82 to 85% on room air. Physician's orders were received on 8/10/12 at 10:45 a.m., for "Chest x-ray today" and "Minineb treatment Albuterol now." The Care Plan Update section of the order indicated a problem of increased congestion, goal of decreased congestion and cough, and interventions of "x-ray, mini-neb now, and seen by Nurse Pract [Practitioner]." A Physician's Progress Note, dated 8 /10/12, indicated, "S [subjective]: Pt [patient] aspirated yesterday. N&V [nausea and vomiting]. Had episode of hypoxia today. CXR [chest x-ray] & O2 [oxygen] ordered. O [objective]: General - in bed resting comfortably Heart - distant Lungs CTAB [clear to auscultation bilaterally]...." The results of the chest x-ray, dated 8/10/12, indicated infiltrates in the lower lobes of the right lung.		**treatment by SDC/designee on or before 9/20/12 with post test included.Licensed nurses will be observed administering/assessing resident during a nebulizer treatment using the nebulizer skills check off.DNS/designee will monitor for complianceNon compliance with these procedures will result in further education including disciplinary action.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be educated on administering/assessing a resident recieving a nebulizer treatment by SDC/designee on or before 9/20/12 with post test included.Licensed nurses will be observed administering/assessing resident during a nebulizer treatment using the nebulizer skills check off.DNS/designee will monitor for complianceNon compliance with these procedures will result in further education including disciplinary action.How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Physician's orders, dated 8/10/12, indicated, "Z-pack [antibiotic] per directions. DX [diagnosis] URI [upper respiratory infection]" and "Albuterol mini-neb tx's [treatments] 0.83%. Inhale 1 vial TID [three times daily] X 4 days." Documentation failed to indicate oxygen was ordered. The Care Plan Update section of the order form indicated a problem of URI, goal of "Will be free from S/S [signs and symptoms] URI by 8/16/12," and interventions of "Meds [medications] per MD order, Mini-nebs per MD order, Encourage fluids." A Nurse's Note, dated 8/11/12 at 2:15 a.m., indicated, "Res resting abed ABT [antibiotic] - URI, [symbol for no] ASE [adverse side effects] noted mini-neb tx [treatment] as ordered. Resp [respiration] even & unlabored. [Symbol for no] cough noted. O2 [oxygen] sats [saturation] 95% on RA [room air]. Will cont. [continue] to monitor." Nursing Notes failed to indicate assessment for signs and symptoms of URI or further monitoring of the resident until 8/11/12 at 5:00 p.m., a period of more than 12 hours. Nurse's Notes on 8/11/12 at 5:00 p.m., indicated the resident fell from her wheel chair and was transferred to the hospital.		**The CQI tool for nebulizer treatment will be utilized weekly x4, monthlyx6 and quarterly thereafter The nebulizer skills check off will be utilized for licensed nurses to ensure nurses are administering nebulozer treatments per order and assessing resident prior to, during and after administering treatment.**Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold. The CQI team will determine need for further review.	

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	The Medication Administration Record for August 2012 indicated the resident received Albuterol minineb treatments on 8/10/12 at 8:00 p.m. and on 8/11/12 at 8:00 a.m. and 2:00 p.m. The facility's policy related to Pulmonary Management was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy indicated for Procedure: Handheld Nebulizer indicated before initiating the treatment "...Performs patient assessment (pulse, breath sounds, respiratory rate, etc.)....Correctly documents all appropriate information into patient's medical records." Attached to the the policy was a Nebulizer Treatment Flow Sheet for documentation of care related to the nebulizer treatment, which provided spaces for documenting heart rate, respiratory rate, and breath sounds before treatment, during treatment, and after treatment, and total minutes of the treatment. During interview on 8/21/12 at 4:35 p.m., the Medical Records Nurse indicated no Nebulizer Treatment Flow Sheet could be located for Resident C. During interview on 8/21/12 at 5:15 p.m., the Director of Nursing indicated the 24 hour reports had been checked, and no			

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	further information related to assessment and monitoring of Resident C was available. This federal tag is related to Complaint IN00113621. 3.1-47(a)(6)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure a resident receiving anticoagulant medications was monitored related to therapeutic dosing for 1 of 1 resident reviewed related to Coumadin therapy in a sample of 11 residents. (Resident A) Findings include: The clinical record for Resident A was reviewed on 8/19/12 at 7:25 a.m. The record indicated the resident was	F0329	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident A is being monitored for coumadin therapy per physician order.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents recieving an anticoagulant have the potential to be**	09/20/2012

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	readmitted to the facility on 7/25/12 following hospitalization for diagnoses including, but not limited to, pulmonary embolism (blood clot in the lung). A physician's order, dated 7/26/12, included, but was not limited to, "Give Coumadin [anticoagulant medication] 5 mg dly [daily] @ 16:30 [4:30 p.m.]" and "Repeat INR [International Normalized Ratio - blood test related to clotting time] Sat [Saturday] 7/28/12." The Care Plan Update section of the order indicated, "Problem: Labs; Goal: Labs WNL [within normal limits]; Intervention: Give meds [medications] per order. Labs as indicated." A Physician Telephone Order received 8/6/12, indicated, "Notified MD of lab PT 18.6/INR 1.8. [Name of physician's staff] from office called back. Coumadin 3 mg po [by mouth] qd [every day] (stays same). D/C [discontinue] Lovenox [injectable anticoagulant medication]. Recheck PT/INR on Thursday (8/9/12). Read back above is correct." Documentation in Nurse's Notes, on the Medication and Treatment Records, and in the Labs section of the clinical record failed to indicate blood was obtained or results reported for the Protime/INR ordered for 8/9/12.		**affected by the alleged deficient practiceAll residents receiving an anticoagulant were assessed and monitored for therapeutic dosing by DNS/designee. Licensed nurses will be educated on monitoring residents on anti-coagulant therapy by the SDC/designee on or before 9/20/12, post test included.** Monitoring of warfarin/Coumadin will be logged on the Coumadin/warfarin tracking log each time a resident has a PT/INR level drawn to include the date the level was drawn, the current dose resident is receiving, the INR result, MD notification and dosage changes/comments.**DNS/designee will monitor for compliance.**Non-compliance with these practices will result in further education including disciplinary action. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses will be educated on monitoring residents on anti-coagulant therapy by the SDC/designee on or before 9/20/12, post test included.** Monitoring of warfarin/Coumadin will be logged on the Coumadin/warfarin tracking log each time a resident has a PT/INR level drawn to	

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	During interview on 8/21/12 at 11:15 a.m., the Director of Nursing phoned the lab. She indicated the lab staff told her the last PT/INR for Resident A was completed on 8/6/12. A Physician's Telephone Order was obtained 8/21/12 for "Obtain PT/INR." This federal tag is related to Complaint IN00113621. 3.1-48(a)(3)		include the date the level was drawn, the current dose resident is receiving, the INR result, MD notification and dosage changes/comments.All physician orders are reviewed daily in the morning clinical meeting to ensure labs are v**DNS/designee will monitor for compliance.**Non-compliance with these practices will result in further education including disciplinary action. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI audit tool for coumadin monitoring will be utilized weekly x4, monthly x6 and quarterly thereafter** Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold. The CQI team will determine need for further review	

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F0332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure medications were administered to residents with an error rate of less than 5%. The deficient practice affected 4 of 6 residents reviewed related to medication administration in a sample of 11 residents. Nine errors in medication administration were observed during 40 opportunities for error in medication administration. This resulted in a medication error rate of 22.5%. (Residents D, A, E, and F) Findings include: 1. On 8/19/12 at 10:05 a.m., LPN #15 was observed preparing medications for Resident D. During interview at this time LPN #15 indicated she was running a little behind. The medications included, but were not limited to, the following: A. An unlabeled Advair inhaler. B. Combivent AER, inhale 6 puffs by mouth every four hours. C. The following medications ordered by	F0332	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident D, Resident A, Resident E, and Resident F** are recieving medications per physician orders and nursing standards of practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficint practice**Licensed nurses will be in-serviced on or before 9/20/12 by the SDC/designee on administering medications to include timeliness and availabilitySkills check offs will be completed for licensed nurses per the SDC/designee onmedication administration on or before 9/20/12A 100% audit of all labels will be conducted to ensure legible and in place- any findings will be reported to pharmacy and replaced.DNS/designee will be responsible for complianceNon compliance with these practices will result in further education includingdisciplinary action **What measures will be put into place**	09/20/2012

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	gastrostomy tube: Digoxin, aspirin, and cholestyramine. LPN #15 crushed the medications for gastrostomy tube administration, gathered the medications and supplies and entered the resident's room. In the resident's bathroom, she poured the crushed medications into a cup and mixed with warm water. She mixed a powdered medication in a cup with warm water, and obtained a cup of water for flushing the resident's gastrostomy tube. LPN #15 donned gloves, stopped the resident's feeding pump for her nutrition by feeding tube and disconnected the feeding tube from the pump tubing. Without checking tube placement or flushing the gastrostomy tube, LPN #15 administered the cups of crushed and powdered medications, flushed the tube with water, reconnected the feeding pump tube, and restarted the resident's feeding. LPN #15 shook the canister of Advair and administered two puffs, one quickly after the other with no second shake or time between. The mouth was not rinsed with water. Immediately LPN #15 administered 6 successive puffs of the Combivent inhaler without pausing between puffs. The resident requested the nurse suction her tracheostomy at that time.		**or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses will be in-serviced on or before 9/20/12 by the SDC/designee on administering medications to include timliness and availability.Skills check offs will be completed for licensed nurses on all shifts per the SDC/designee on medication administration on or before 9/20/12.DNS/designee will be responsible for compliance.Non compliance with these practices will result in further education includingdisciplinary action **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI audit tool for pharmacy services will be completed weekly x4,monthly x2 and quarterly x 1 quarter.The skills checkoff will be completed weekly x4 weeks, monthly x6 months and quarterly thereafter. Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold. The CQI team will determine need for further review.**	

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	The clinical record for Resident D was reviewed on 8/21/12 at 9:55 a.m. The record indicated physician's rewrite orders for August 2012 including, but not limited to, a. An order originally received 4/5/12 indicated, "Advair HFA 115/21 AER [aerosol], inhale 2 puffs via inhalation twice daily - COPD [chronic obstructive pulmonary disease]." The orders indicated the medication was scheduled for administration at 9:00 a.m. On 8/22/12 at 7:00 a.m., review of package insert information on-line at http://us.gsk.com/products/assets/us_advair_hfa.pdf indicated the following: "...2. ...Breathe out through your mouth and push as much air from your lungs as you can.... 3. ...Right after the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth. 4. Hold your breath as long as you can, up to 10 seconds, then breathe normally. 5. Wait about 30 seconds and shake the inhaler again for 5 seconds. Repeat steps 2 through 4. 6. After you finish taking this medicine, rinse your mouth with water. Spit out the water. Do not swallow it...."			

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	b. An order originally received 4/5/12 indicated, "Combivent AER, inhale 6 puffs every 4 hours - DX [diagnosis] respiratory failure." The orders indicated the medication was scheduled for administration every four hours beginning at midnight, with a scheduled dose due at 8:00 a.m. The medication was administered at least one hour and five minutes after the one hour before/one hour after the scheduled dose time. On 8/22/12 at 7:15 a.m., review of package insert information on-line at http://bidocs.boehringer-ingelheim.com/BIWebAccess/ViewServlet.ser?docBase=renetnt&folderPath=/Prescribing+Information/PIs/Combivent+IA/combivent.pdf indicated the following: "...4. Shake the canister vigorously for at least 10 seconds...IMPORTANT: Vigorous shaking for at least 10 seconds before each spray is very important for proper product performance.... 5. Breathe out (exhale) deeply through your mouth.... 6. Breathe in (inhale) slowly through your mouth and at the same time spray the product into your mouth.... 7. Hour your breath for 10 second, remove the mouth piece from your mouth and breathe out slowly.... 8. Wait approximately 2 minutes, shake the inhaler vigorously for at least 10 seconds again..., and repeat Steps 5 to 7...."			

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	2. On 8/19/12 at 10:25 a.m., LPN #15 was observed preparing medications for Resident A. The medications included, but were not limited to, medications labeled as follows: A. Furosemide 40 mg, one by mouth twice daily. B. During interview at this time, LPN #15 indicated the resident had a dose of Avapro due, but the medication was not on the medication cart, and she would need to check the EDK (Emergency Drug Kit) for the medication. LPN #15 entered the resident's room, checked vital signs, and administered the medications prepared. She proceeded to the Medication Room, checked the EDK, and indicated the medication was not in the EDK. The medication was not administered. The clinical record for Resident A was reviewed on 8/19/12 at 7:25 a.m. Physician's rewrite orders for August 2012 included, but were not limited to, the following medication orders: a. An order originally dated 1/21/11, for "Furosemide 40 mg tab, take 1 tablet by mouth twice daily. DX: CHF			

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	[congestive heart failure]." The orders indicated the medication was scheduled for administration at 9:00 a.m. and 5:00 p.m. The medication was administered at least 25 minutes after the one hour before/one hour after the scheduled dosing time. b. An order originally dated 7/25/12, for "Irbesartan [Avapro] 150 mg tab, take 1 tablet by mouth once daily. DX: Hypertension." 3. On 8/19/12 at 10:40 a.m., LPN #15 was observed preparing medications for Resident E. During interview at this time, LPN #15 indicated the resident also should receive a dose of Alfuzosin, but the medication had not yet been received from the pharmacy. LPN #15 indicated that sometimes on the week-end the pharmacy is slow to deliver medications. The medication was not administered. The clinical record for Resident E was reviewed on 8/21/12 at 10:05 a.m. Physician's Orders for August 2012 included, but were not limited to, the following medication orders: An order originally received 7/28/12 for "Alfuzosin ER 10 mg PO dly [daily] (BPH) [benign prostate hypertrophy]." 4. On 8/19/12 at 10:45 a.m., LPN #15			

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	was observed preparing and administering medications labeled as follows for Resident F: A. LPN #15 obtained a bottle of Metoclopramide 5mg/5ml from the medication drawer. She indicated a spill had obliterated the information on the medication label. She was observed to measure 5 ml of the medication into a medication cup. B. Budesonide INH 0.5 mg/2ml, use 1 vial per nebulizer twice daily. C. Carvedilol 3.125 mg tab, 1 by mouth twice daily. LPN #15 crushed the medications and entered Resident F's room and mixed the medications and with water in cups. LPN #15 donned gloves, stopped the continuous tube feeding pump, disconnected the gastrostomy tube from the pump, and without checking placement or flushing the tube, poured the cups crushed and powdered medications mixed with water into the tube, flushed with water and reconnected the tube and started the feeding. LPN #15 then set up and administered the nebulizer treatment. The clinical record for Resident F was reviewed on 8/21/12 at 10:15 a.m. The			

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	record indicated Physician's Rewrite Orders for August 2012 including, but not limited to, An order originally received 3/27/12, for "Check placement of PEG tube every shift prior to administering meds" and "Flush tube prior to and after medication administration with 30cc water." a. An order originally received 4/26/12, for "Metoclopramide 5mg/5ml sol [solution], give 5 ml (5 mg) four times daily. DX: abdominal pain." The orders indicated the first daily dose was scheduled at 9:00 a.m., and the second dose was scheduled at 1:00 p.m. The first dose was administered at least 45 minutes after the one hour before/after the scheduled dosing time. b. An order originally dated 3/28/12, for "Budesonide INH 0.5mg/2ml, use 1 vial per nebulizer twice daily." The orders indicated the first daily dose was scheduled at 9:00 a.m. was administered at least 45 minutes after the one hour before/one hour after the scheduled dosing time. The resident also received a different nebulizer medication at 6:00 a.m. and 12 noon. c. An order originally dated 5/16/12, for "Carvediol 3.125 tablet, 1 by mouth twice			

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	daily. Hold if systolic blood pressure is <90 [less than 90]." The orders indicated the medication was scheduled at 9:00 a.m. and 5:00 p.m. The medication was administered at least 45 minutes after the one hour before/one hour after scheduled dosing time. The medication was administered by gastrostomy tube. During interview on 8/21/12 at 11:35 a.m., RN #13 indicated Resident F receives a tray but does not eat well. She indicated the resident takes all her medications through the gastrostomy tube. The pharmacy policy for Medication Administration Guidelines was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy included, "...Medications can be administered within a two hour time frame (one hour before to one hour after the time prescribed)....Administering medications too early or too late is considered a medication error...." This federal tag relates to Complaints IN00113535, IN00113621, and IN00114469. 3.1-25(b)(9) 3.1-48(c)(1)			

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F0425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. A. Based on observation, record review, and interview, the facility failed to ensure policies related to pharmacy services were followed for resident identification. The deficient practice related to resident identification affected 26 of 72 residents whose medication records were reviewed. B. Based on observation, record review, and interview, the facility failed to ensure the pharmacy provided medications timely as needed by residents. The deficient practice affected 2 of 6 residents observed during medication pass in a sample of 11. (Residents A and E)	F0425	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?All residents have identifiers in the MARs and TAR's.Resident A's is receiving medications per physician orders and standards of nursing practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.All residents**	09/20/2012

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	Findings include: A.1. The pharmacy policy for Medication Administration Guidelines was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy included, but was not limited to, "...Before giving a medication, the nurse must follow the FIVE "R's": THE RIGHT RESIDENT.... After the resident has been identified, and the medication has been given...." The facility policy for Identification of a Resident indicated, "This facility will provide a means to identify the resident by use of an identification bracelet and/or current photograph of each resident....If photographs are used for resident identification, photographs of the resident are taken on admission, and with any significant change while residing in the facility....The photographs should be placed in the Medication Administration Record. Identification on bracelet and photograph includes resident name, room number, admission date, and attending physician.... If a photograph is missing or no longer accurate, a new photograph will be taken and placed in the designated area." During interview on the Initial Tour on 8/19/12 at 6:15 a.m., RN #9 indicated she was new to the facility and was slow on		**MAR's and TAR's were reviewed to ensure identifiers were in place by DNS/Designee. All residents medications were reviewed to ensure medications prescribed were available as ordered by DNS/Designee.** Pictures were taken of all residents and are present in their MAR's and TAR's for identification. New admissions to the facility will have their pictures taken by nursing administration/designee and placed in their MAR/TAR.Licensed nurses will be educated on re-ordering medications timely to ensure allmedications are available as prescribed by their physicians by the Pharmacy consultant on or before 9/20/12.Night shift nurses will be responsible to check med carts daily to ensure medications are re-ordered before current supply exhausts.The DNS/designee is responsible for complianceNon-compliance with these practices will result in further education includingdisciplinary action. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The charge nurses are responsible for ensuring the pictures are in present on the MAR's and TAR's for identification. Any areas of non-compliance will be	

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	the medication pass yesterday, because she was learning the residents' names and their medications. She indicated she had to ask CNAs who was who to be sure she had the right resident. She indicated not all residents had pictures in the Medication Administration Record, and from the pictures she wasn't always sure who the residents were. Review of the Medication Administration Record binders on 8/20/12 at 3:40 p.m. indicated the following: 2-South (two binders): 23 residents had photographs and 5 residents had no photographs; 2-East: 19 residents had photographs and 7 residents had no photograph; Transitional Care Unit: 8 residents had photographs and 14 residents had no photograph. During interview on 8/21/12 at 9:30 a.m., the Administrator indicated residents' photographs had now been printed out of the camera and placed on the Medication Administration Records. B.1. On 8/19/12 [Sunday] at 10:25 a.m., LPN #15 was observed preparing medications for Resident A. During		immedicately reported. New admissions to the facility will have their pictures taken by the nursing administration/designee and placed in their MAR/TAR.Licensed nurses will be educated on re-ordering medications timely to ensure allmedications are available as prescribed by their physicians and the 5 rights for administering medications by the Pharmacy consultant/Designee on or before 9/20/12.Night shift nurses will be responsible to check med carts daily to ensure medications are re-ordered before current supply exhausts.The DNS/designee is responsible for compliance.Non-compliance with these practices will result in further education includingdisciplinary action**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI tools for pharmacy services and resident identification will be utilized weekly x4, monthly x6 and quarterly thereafter Findings from the CQI process will be reviewed monthly and an actionplan will be implemented as needed for any deficient practices below 95%** threshold. The CQI team will determine need for further review	

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	interview at this time, LPN #15 indicated the resident had a dose of Avapro due, but the medication was not on the medication cart, and she would need to check the EDK (Emergency Drug Kit) for the medication. LPN #15 and administered the medications prepared. She proceeded to the Medication Room, checked the EDK, and indicated the medication was not in the EDK. The medication was not administered. B.2. On 8/19/12 [Sunday] at 10:40 a.m., LPN #15 was observed preparing medications for Resident E. During interview at this time, LPN #15 indicated the resident also should receive a dose of Alfuzosin, but the medication had not yet been received from the pharmacy. LPN #15 indicated that sometimes on the week-end the pharmacy is slow to deliver medications. The medication was not administered. The facility's policy for "Delivery Schedule" was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy included, but was not limited to, "...[Name of facility's pharmacy] will have a minimum of one scheduled delivery per day, Monday thru Saturday, with the delivery leaving the pharmacy at approximately 9:00 p.m. (subject to change). Note: There is no scheduled			

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	delivery on Sunday or Holidays...." This federal tag relates to Complaints IN00113535, IN00113621, and IN00114469. 3.1-25(a) 3.1-25(e)(1)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were labeled in accordance with pharmacy policies. The deficient	F0431	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident D**	09/20/2012

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	practice related to labeling affected 2 of 6 residents whose medications were observed related to labeling in a sample of 11. (Residents D and F) Findings include: 1. On 8/19/12 at 10:05 a.m., LPN #15 was observed preparing medications for Resident D, including an Advair inhaler. The inhaler was not in a baggie with a label, and the resident's name was not on the inhaler canister. LPN #15 looked in the medication drawer, and during interview at this time, she indicated she was unable to find the labeled baggie for the resident's Advair. She indicated she knew it belonged to the resident, because she was the only resident using an Advair inhaler. LPN #15 also indicated the resident's name was not on the inhaler canister. 2. On 8/19/12 at 10:45 a.m., LPN #15 was observed preparing medications for Resident F. LPN #15 obtained a bottle of Metoclopramide 5mg/5ml from the medication drawer. She indicated a spill had obliterated the information on the medication label. She was observed to measure 5 ml of the medication into a medication cup. The facility's policy for "Labeling of		**medications are appropriate labeled. Resident F medications have a new label per pharmacy policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.**Licensed nurses will be educated on pharmacy policies regarding labeling ofmedications by the Pharmacy consultant on or before 9/20/12, post test included.A 100% audit of all medications will be completed to ensure all labels are legible and present by the pharmacy consultant. Labels found not meeting pharmacy policies will be replaced.The DNS will be responsible for complianceNon-compliance with these practices will result in further education includingdisciplinary action**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses will be educated on pharmacy policies regarding labeling ofmedications by the Pharmacy consultant on or before 9/20/12, post test included.A 100% audit of all medications will be completed to ensure all labels are legible and present by the pharmacy	

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	Medication" was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy indicated the following: "...6.02 Medication Labeling: Medication labels are not to be: Dirty, illegible, defaced, altered, or revised. When the label becomes soiled and/or illegible the medication will be destroyed in accordance with State and Federal Laws....." The policy also indicated, "...6.10 Difficult Labeling: When it becomes difficult to attach the medication label directly to the medication container because of size or shape, [name of pharmacy provider] will attach the medication label to the companion box or baggie or vial and insert the medication container. The medication container will have a small auxiliary label attached to it which contain the following information: Patient Name, Medication Name and strength (if applicable), Quantity dispensed, Rx [prescription] number, Date dispensed, Directions for Use. After the medication is used it must always be returned immediately to the labeled box, baggie, or vial...." This federal tag relates to Complaints IN00113535, IN00113621, and IN00114469. 3.1-25(k)(1) 3.1-25(k)(2)		consultant. Labels found not meeting pharmacy policies will be replaced. Charge Nurses are responsible for ensuring that the medications have the appropriate label and legible during their med pass each shift. Pharmacy will be notified if replacement labels are indicated.The DNS wil be responsible for complianceNon-compliance with these practices will result in further education includingdisciplinary action **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI audit tool for pharmcy services will be utilized weely x4, monthly x6 and** quarterly thereafter Findings from the CQI process will be reviewed monthly and an action plan willbe implemented as needed for any deficient practices below 95% threshold. The CQI team will determine need for further review.	

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	3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure	F0441	**What corrective action(s) will be accomplished for those**	09/20/2012

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	hand washing and glove use in accordance with the facility's infection control policies for 5 of 7 residents observed during care from a sample of 11 residents. (Residents D, A, E, F, and K) Findings include: 1. On 8/19/12 at 10:05 a.m., LPN #15 was observed at the medication cart preparing medications for Resident D. LPN #15 dispensed medications from blister pack cards, popping the medications from the cards into her ungloved fingers and placing the medications in a medication cup. The resident's Digoxin tablet dropped onto the top of the medication cart, and the nurse picked it up and placed it in the medication cup. She crushed the medications, gathered medications for inhalation treatment, and entered the resident's room. LPN #15 obtained cups of water from the bathroom for use during administration of the medications by gastrostomy tube. She donned gloves, administered the medications by gastrostomy tube, removed the gloves, and without washing her hands or using hand sanitizer, administered the inhalers. The resident indicated she needed to be suctioned through her tracheostomy tube. Without washing her hands or using hand sanitizer, LPN #15 donned sterile gloves		**residents found to have been affected by the deficient practice?Resident D shows no evidence of harm by alleged deficient practice.**Resident A, Resident E, Resident F, and Resident K are recieving the appropriate care based on the infection control policies and practices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.**Nursing Staff will be re-educated on hand washing, use of gloves policy and procedures by the SDC/designee on or before 9/20/12 with post test included.Skills checks will be completed for nursing staff by the SDC/designee on or before 9/20/12.DNS/designee will be reponsible for outcomes.Non-compliance with these practices will result in further education including disciplinary action **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Nursing Staff will be re-educated on hand washing, use of gloves policy and infection control policy and procedures by the SDC/designee on or before 9/20/12 with post test	

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	and suctioned the resident. She removed the gloves, and without washing her hands or using hand sanitizer, returned to the medication cart, stored supplies, and documented on the Medication Administration Record. 2. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:25 a.m., LPN #15 began preparing medications for Resident A. She dispensed medication from blister pack cards, popping the medications from the cards into her ungloved fingers and placing the medication into a medication cup. LPN #15 entered Resident A's room, checked her vital signs and administered her oral medications. Without washing her hands or using hand sanitizer, she went to the Medication Room to check the Emergency Drug Kit for another medication for Resident A. Without washing her hands or using hand sanitizer, she returned to the medication cart. 3. On 8/19/12 at 10:40 a.m., LPN #15 began to prepare medications for Resident E, who was standing at the medication cart. She dispensed medication from blister pack cards, popping the medications from the cards into her ungloved fingers and placing the medication into a medication cup. She		included.Skills checks will be completed for nursing staff by the SDC/designee on handwashing and glove usage on/or before 9/20/12.Nursing Administration will conduct daily rounds and monitor infection control practices as it relates to handwashing and glove use.DNS/designee will be reponsible for outcomes.Non-compliance with these practices will result in further education including disciplinary action**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CQI audit tools for infection control will be utilized weekly x4, monthly x6 and quarterly thereafter Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below 95%**threshold. The CQI team will determine need for further review	

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	checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m., LPN #15 began preparing medications for Resident F. She entered the resident's room with medications and supplies, obtained water for gastrostomy tube medications from the bathroom, donned gloves, and administered the resident's medications by gastrostomy tube. She removed her gloves, and without washing her hands or using hand sanitizer, she donned another pair of gloves and administered an injection into the resident's abdomen. She removed her gloves. Without washing her hands or using hand sanitizer, she used an electronic device to check the resident's oxygen saturation and set up the resident's nebulizer treatment. Without washing her hands or using hand sanitizer, she left the room, replaced electronic devices in the medication cart, and indicated she was ready to prepare medications for the next resident. 5. On 8/21/12 at 12:10 p.m. CNA #18 and the Director of Nursing (DON) were observed in the room of Resident K preparing to transfer the resident from bed to chair with a Hoyer lift. The resident			

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	155203	A. BUILDING 00 B. WING	08/21/2012

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	was observed to have a dark red rash area on the right side of the back at the waistline. The DON was interviewed about the rash. She began to look at the area and was observed to touch the resident's skin near the rash area with an ungloved hand, as she leaned in to see more clearly. She then indicated, "Let me get..." and stepped to the glove dispenser on the wall. She donned gloves and completed the assessment. She indicated the resident's nurse just left the room to get an order for treatment to the rash. The facility's policy for "Gloves" was provided by the Medical Records Nurse on 8/21/12. The policy indicated hands are washed before putting on and after taking off gloves. 3.1-18(l)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview, and record review, the facility failed to ensure documentation on the Weekly Skin Assessment was complete and accurate for 1 of 11 residents reviewed related to accurate documentation in a sample of 11 residents. (Resident K) Findings include: On 8/19/12 at 8:10 a.m., Resident K was observed receiving personal care. A red skin rash area was observed on the right side of the resident's back near the waistline. During interview at this time, CNA #18 indicated she had observed cream on the area previously. On 8/19/12 at 12:15 p.m., the Administrator indicated "skin sweeps"	F0514	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident K was re-assessed and an accurate assessment was completed and placed in the medical record. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practiceLicensed nurses will be re-educated on the policy/procedure on completing weekly skin assessments by the SDC/designee on or before 9/20/12 with post test included.A 100 % facility skin sweep will be conducted on or before 9/20/12 to ensure residents with	09/20/2012

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	had been just been completed on 8/19/12 on Resident K's unit. The Administrator provided a copy of the "Weekly Skin Assessment" for Resident K, dated 8/19/12. In the blank following "Discoloration/Rashes" was a check mark next to "No." On 8/21/12 at 12:10 p.m., Resident K was observed in bed. On the right side of the resident's back near the waistline was observed a dark red skin rash area. A small red line of rash was observed on the left side of the resident's back. During interview at this time, the Director of Nursing indicated Resident K's nurse had just left the room and was contacting the physician for an order for treatment of the area. 3.1-50(a)(2)		any alteration in skin integrity have all components complete (i.e. MD/family ntoification, treatment ordered, weekly measurements/monitoring). Charge nurses will conduct weekly skin assessments and results of the assessment will be documented.DNS/designee will be responsible for compliance.Non-compliance with these practices will result in further education including disciplinary action.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All residents have the potential to be affected by the alleged deficient practiceLicensed nurses will be re-educated on the policy/procedure on completing weekly skin assessments by the SDC/designee on or before 9/20/12 with post test included.A 100 % facility skin sweep will be conducted on or before 9/20/12 to ensure residents with any alteration in skin integrity have all components complete (i.e. MD/family ntoification, treatment ordered, weekly measurements/monitoring)DNS/designee will be responsible for compliancenon-compliance with these practices will result in further education including disciplinary action.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur,**	

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			i.e., what quality assurance program will be put into place? The CQI audit for skin management program will be utilized weekly x4, monthly x6 and quarterly thereafter Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below 95% threshold. The CQI team will determine futher need for review.	